

Practice Improvement Protocol 15

The Unique Behavioral Health Service Needs of Children Involved with CPS



**Developed by the
Arizona Department of Health Services
Division of Behavioral Health Services**

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ISSUE: This protocol outlines the clinical considerations necessary to serve children involved with Child Protective Services (CPS), their families and other caregivers.

PURPOSE: To provide an understanding of the unique behavioral health service needs of children involved with CPS, and guidance to Child and Family Teams in responding to those needs.

TARGET POPULATION: All children under the age of 21 who are involved with CPS (including those living with their own families, in foster care, kinship care, in adoptive families and independent living situations), and are referred to the behavioral health system.

BACKGROUND: While any child might experience trauma, loss, or anxiety, children involved with the child welfare are exposed to life transitions to which children with those problems, who remain with their families, are never exposed. Child welfare mandates that children will experience safety, permanency and well-being – mandates that overlap the functional outcomes toward which behavioral health services are intentionally provided.

PROCEDURES:

1. Working in Partnership

Efforts to meet the unique service needs of children involved with child welfare are best supported when the behavioral health system, child welfare, other involved agencies (e.g. juvenile justice, DDD) and service providers (including pediatricians and day care providers) work collaboratively towards consistent goals developed in unified service planning processes. The Child and Family Team (CFT) and compatible team decision-making processes provide the platform for unified assessment, service planning and delivery. The CFT must strive to fully understand the unique needs of each family. Consistent and compatible planning should include school, health care, early intervention, juvenile justice, childcare or other involved entities to promote interagency concordance. Continuity of the team, and its clinical representative(s), is especially important throughout the child's transitions.

Whether initiated by an urgent behavioral health response after a child's removal by CPS from his/her home, by placement out-of-home (e.g. Level I, II or III residential programs), or by referral from CPS as part of an in-home intervention plan, the behavioral health system should begin to address the child's needs at the earliest moment. This allows the behavioral health system to understand, shape, and align its efforts with, the child welfare case plan. If the child is removed from his/her family of origin, for example, with a case plan focused on reunification, then behavioral health services should support that plan, including services and supports needed for parents. If the child must live with temporary caregivers (e.g. an uncle, a foster family), then behavioral health services should also support those caregivers in order to achieve stability for the child in the temporary placement, and to respond to the other identified behavioral health needs of the child.

The behavioral health system should support CPS' legal mandates by:

- using a Child and Family Team process to identify and describe the strengths, needs and important cultural considerations of the child and family,
- using the CFT process to develop behavioral health service plans, and to present recommendations and options to the juvenile court as appropriate; and
- furnishing information and reports about the provision of behavioral health service provision that may be required by CPS and the juvenile court.

Service Expectations: Behavioral health service plans must be consistent with plans developed by other agencies serving the child or family and in accordance with their mandates. Whenever possible, integrated service plans should be developed, and jointly implemented.

2. Addressing Needs in the Context of Each Child's Family

The family circumstances that lead to involvement by CPS can be expected to create needs for behavioral health treatment and/or support for most children, and may reflect such needs of the family as a whole, or family members. In order to appropriately address their behavioral health needs, interventions should extend beyond the identified needs of the child alone, and should consider the needs of the family as they relate to the safety, permanency, behavioral health and wellbeing needs of the child. Together, CPS, behavioral health and other involved agencies should identify resources to support the needs of both family and child.

The involvement of CPS often indicates the presence of significant safety and risk concerns and needs. It is important that the Child and Family Team understand these concerns and explore opportunities where behavioral health services can help to mitigate them. At the same time, the Child and Family Team should work with CPS to comprehensively assess the strengths and resources of each child, the child's family and community. These strengths and resources can fortify the child's abilities at any age to cope with problems and adapt to changes -- a concept called *resilience*. CPS, behavioral health and other involved agencies should coordinate their services with other public and private services and supports through individually tailored approaches that identify, apply, support and strengthen such assets, and that address any safety and risk issues.

Families -- whether the child's family of origin, a foster family, a relative or friend providing kinship care, or an adoptive family or care-giving legal guardian -- may be supported through the individual service plan of the child with supports and/or interventions such as respite, family support, peer support, living skills training (e.g. positive behavior support) or family counseling. The behavioral health system may often need to provide service approaches traditionally offered by the child welfare system, such as (intensive) family preservation services, in order to help stabilize the family situation and address the reasons for CPS involvement with the family.

It is the responsibility of the Behavioral Health System to provide needed interventions to family members, including siblings, who may also need specific individualized treatment, including individual counseling or other focused interventions. When this occurs service plans must be coordinated to make them compatible and mutually reinforcing. Without diminishing the needs that may exist for individual interventions, the Child and Family Team should participate in an overall plan that makes sense to the family, meets the requirements of CPS and the juvenile court, and is therefore more likely to be effectively implemented.

Service expectations: Behavioral Health Service Plans must include both generic resources and services as well as covered behavioral health services, and must include services needed by families and other caregivers.

3. When the Child Remains with His/Her Own Family

Children involved with CPS often live in family homes where CPS is actively monitoring identified concerns relating to safety, security or basic needs. Likely emotional responses of children in such circumstances might include:

- disturbed parent-child and child-sibling relationships

- disrupted capacity for trust and attachments
- anxiety
- developmental delays or compromised learning
- dysfunctional coping skills
- behavioral disturbances
- post traumatic stress disorder,
- mood disturbances, and/or
- physical complaints or symptoms like headaches, abdominal pain or bedwetting.

Behavioral health intervention and support can be most effective when provided to prevent a child's removal to protective foster care. Some of these responses might further be associated with – or indicate potential need for -- substantial involvement in primary health care, juvenile justice, special education and/or developmental disabilities systems. The behavioral health system must furnish sufficient capacity to address pivotal needs as part of a collaborative in-home intervention with CPS, sometimes with the juvenile court, and sometimes other child-serving systems.

A child remaining at home with a family involved with CPS needs assurance of a positive and safe future – that is, that he/she can rely on the adults in the household to place his/her needs first. Such children may need to develop or strengthen supportive relationships with others – both age peers and adults – as well. To meet these unique needs, services with most families will need to be intense, comprehensive and delivered quickly in order to maximize engagement with the family and to strengthen their existing support systems with added resources. When CPS-contracted in-home services are also in place, then behavioral health services and supports should work in concert with those services.

Parents in this situation should be helped to learn/know how to manage their child's unique needs, and to anticipate and respond to those needs as they change. Services and supports provided to such families should be designed to impart skills and confidence to the parents, while protecting the children (i.e. to limit and reduce risk of harm to them) to prevent a need for their removal to protective foster care. Siblings and other family members should be incorporated in service planning and delivery, and advised of choices they may exercise in the process.

The Clinical Liaison must ensure the provision of covered behavioral health services identified by the CFT which promote the child's ability to live and thrive in his/her own family home, with safety and stability.

Service expectations: The RBHA must develop and implement a process to identify barriers and unmet service needs identified by the CFT. This mechanism must ensure that needed services are promptly provided and barriers to service are rapidly removed.

4. When the Child Is Removed to Protective Foster Care

The presence of serious safety concerns may require CPS to remove children from their family homes to protective placements (shelters, receiving homes, relative ["kinship"] placements, family foster homes or group homes). A child who may already have been seriously neglected or abused (physically, sexually, emotionally) within the family home will be affected, then, not only by the neglect or abuse that precipitated removal to protective foster care; but also by the removal itself. The child may experience trauma, disorientation and uncertainty related to such a drastic change in his/her life circumstances.

The removal of a child from his/her family home to the protective custody of CPS is, *per se*, an urgent behavioral health situation. Consequently, the RBHA shall respond within 24 hours of a referral from CPS surrounding a child's removal. Each RBHA and DES-ACYF district in all regions of Arizona have jointly established local protocols implementing this requirement. The Urgent Behavioral Health Response for Children Entering Foster Care is intended to:

- identify immediate safety needs and presenting problems in the child,
- provide direct therapeutic support to each child,
- provide direct support to each child's new caregiver,
- initiate the development of a Child and Family Team, and
- provide CPS and the juvenile court with findings and recommendations to inform the child's case plan, beginning by the preliminary protective hearing.

Foster parents and other protective caregivers must be considered to be significant, knowledgeable members of the CFT. They should experience well-integrated coordination among, and clear communication from, all involved systems, beginning immediately upon placement of the child. Foster parents and other protective caregivers will need guidance and support to raise children facing the challenges of neglect/abuse and subsequent removal from their family homes. The caregivers will need guidance to understand how to recognize indicators of each child's adjustment, how to respond to and seek any necessary outside assistance to address poor coping the child may demonstrate in his/her new situation, and how to support any treatment for the child and/or family.

When children are removed to protective foster care, their own parents may need to:

- be convinced that "my child needs me sooner rather than later,"
- learn how to analyze problems, and how to solve them in collaboration with others, especially in relation to the safety needs of the family members,
- be engaged (and even re-engaged) to participate in assessment, service planning and delivery processes for their children and themselves as appropriate, and
- have regular, appropriate contact with their children in order to protect their bond and relationship with their children unless contraindicated by the child welfare case plan.

The behavioral health system should also help CPS workers, judges, attorneys, court-appointed special advocates (CASAs) and others to understand useful service approaches, as well as the importance of their respective relationships with the child, and their potential to impact the child's overall development.

Children who have been removed by CPS from their family homes because of neglect or abuse might manifest the following emotional responses to such circumstances:

- disrupted parent-child and child-sibling relationships
- disrupted capacity for trust and attachments
- anxiety
- developmental delays or compromised learning
- dysfunctional coping skills
- behavioral disturbances
- post traumatic stress disorder
- mood disturbances, and/or
- physical complaints or symptoms like headaches, abdominal pain or bedwetting.

In addition, some children may need specially informed treatment to address their victimization by sexual abuse, including specific interventions for such children who act out in a sexually aggressive manner.

It is very likely that any child who has experienced removal will be emotionally affected in some way. Foster children who do not initially demonstrate overt mental health symptoms may still require active therapeutic intervention, might be involved in family-focused services, and will certainly benefit from close observation and documentation by trained eyes. All children referred by CPS who have been removed from their homes must be evaluated by Behavioral Health within 24 hours and, regardless of their initial presentation, reevaluated within at least 30 days. A minority of foster children who are transitioned from family home to foster care placement without apparent ill effects will, nevertheless, benefit from activities and strategies that help to fortify their resilience, that anticipate and prepare them for the subsequent life transitions inherent in child welfare practice and, depending on age, for their passage into adulthood. The CFT should help to protect familial relationships, ensuring that regular and appropriate visitations and other contact among siblings, and between children and their birth families, are addressed, described and supported in the service plan.

Service expectations: A Behavioral Health Assessment must be provided within 24 hours to every child removed and identified by CPS. Regardless of the initial finding of the assessment, or initial services provided, a re-evaluation must occur within 30 days. During this process, Clinical Liaisons and service providers must extend service provision as needed to Foster Families and other protective caregivers, and must serve as educational and supportive resources for staff from other child-serving agencies.

5. When the Child Returns to His/Her Family of Origin from Foster Care

Children who have been living apart from their families of origin have had time, while in protective foster care, to adapt to new expectations, interactions, roles and experiences. Coping skills and behavioral response patterns have likely been adapted to the dynamics of the protective caregivers, and these may be distinct from those of their own families.

At the same time, their families of origin will likely have adapted to new daily realities that have not included the child.

Consequently, visitation and contact must be promoted and maintained with family members and other anchoring relationships (e.g. friends, extended family, teachers) to the greatest extent possible. The Child and Family Team should consider the needs of the child, his family and his protective caregivers surrounding such visitation and other contact, including opportunities for therapeutic support and to promote the practice of new skills and behaviors that successful reunification will require. All involved parties will need to understand how to optimize transition processes, according to the child's age (e.g. the younger the child, the shorter the transition) or level of maturity; and specific circumstances, and how to support productive transition strategies from their respective positions.

Regardless of the planning and work that is done to prepare for the child's return home, reunification should be expected to be stressful and difficult. Unresolved issues relating to neglect, abuse, abandonment, fear and mistrust may resurface. Memories and symptoms of post-traumatic stress disorder may be triggered by re-exposure to the home environment. Familiar but dysfunctional family coping patterns may return and threaten to replace recently learned adaptive patterns. The

CFT should focus on preparing both the child and the family for reunification, ensuring that appropriate service (including crisis) plans are in place as needed.

Children will require tailored and individualized behavioral health services to meet the specific needs that stem from reunification. Behavioral health providers and child welfare professionals must work collaboratively to promote feelings of:

- being embraced, re-accepted and not blamed (e.g. for the initial removal) by their reunified families;
- being wanted, permanently;
- assurance that their families will put the children's needs first; and
- confidence that the stay with their families will last.

Service expectations: Clinical Liaisons and service providers must coordinate with staff from other child-serving agencies involved in a reunification process by providing appropriate counseling, family support, education and related behavioral health family reunification services.

6. When the Child Achieves Permanency through Adoption or Guardianship

Children who leave foster care for other permanent situations (adoption, guardianship) may experience significant feelings of loss, at the same time their permanency is viewed as a success by CPS, the juvenile court, their new families and even by themselves. Many adopted children experience feelings of isolation and being different. They may feel irreversibly abandoned by their families of origin, engendering anger, feelings of guilt and even self-blame. The adopted child may experience the loss not only of both natural parents, but also of extended family, of cultural and genealogical heritage, of a sense of connectedness, of former social status and personal identity. (Such losses are rarely recognized in the context of adoption, and few supports have been made available to children experiencing them.)

The same children may strive for, and be integrating, new feelings of gratitude, inclusion and acceptance. Children entering new ties through adoption or guardianship are likely to strive to gain a new sense of identity and belonging – a feeling of “fitting in” – in their new home and community. Given their prior losses, they are likely to need reassurance that “I am wanted, no matter what I do or how I act.” Many will choose to test limits repeatedly to try the strength of their new ties as they adjust. Children in adoptive or guardianship situations need to know that their past will be considered by others and included in their futures.

These emotional responses may occur on top of existing needs issues such as abuse and neglect, the trauma of separation at the point of removal from all that was familiar, the adaptation challenge posed to the child by his/her new world of foster care, and the additional transitions the child most likely endured within foster care. (All children eligible for the Adoption Subsidy program remain categorically eligible for Title XIX behavioral health services for the duration of their childhoods.)

The Child and Family Team must organize to meet the many needs of the child. These include helping the child to understand what adoption/guardianship means, and to name and manage confusing feelings. (This is not to insist that such conversations will always occur during meetings of the CFT itself; indeed, often the team will identify the need for such feelings to be addressed in the context of individual, family or group therapy instead.) The Child and Family Team must support the child to prepare for success in the new family situation: how to optimally adjust, to practice

productive new behaviors, to set and achieve concrete goals, and how to access additional assistance when problems occur.

The Child and Family Team must recognize that the child's new family, too, will need adequate preparation and support to successfully absorb a new family member – and one who is prone to emotional issues. Every member of the child's new family will be affected by the changing relationships within the family system. They may need to be prepared for complex emotional and behavioral issues often presented by children leaving foster care to adopting families, and to anticipate that the older the child, and the longer he/she has been in foster care, the more challenges and limit-testing will be likely. Supportive behavioral health services must be readily available, consistent, and sufficiently prepared to meet the unique needs of children and adoptive families. Adoptive parents will feel the need to be fully recognized as the child's parent, and reassured that they will know what to do when faced with the child's adjustment issues over time.

Safe people from the child's family of origin or past support system, and who remain important to the child, should remain involved in the child's life as much as possible. This dimension, too, may require assistance by the behavioral health provider, intended to ensure that the child and his/her new family can have positive connections to the child's past. The Child and Family Team should continue involving those safe people in the ongoing planning and treatment process.

Service expectations: Services plans must consider the issues that typically surface for both children and families involved in the adoption process.

7. Special Considerations for Infants, Toddlers and Preschool-Aged Children

The Child and Family Team can contribute to the wellbeing of infants, toddlers and young children by helping other involved partners to view the child holistically, sharing awareness of the connections among their helping efforts and implications for the children and their caregiving families. Clinical Liaisons will be expected to facilitate a specialized assessment approach prescribed by ADHS that supports this holistic perspective. The behavioral health expertise they bring to the Child and Family Team must:

- help family members to appreciate the impact of their interactions on young children (most therapeutic work at this age is likely to focus on those interactions and relationships -- individual interventions with such young children are rarely indicated);
- recognize signs, symptoms and indicators of other needs (e.g. speech delays, sensory challenges, secondary effects of maternal substance abuse) that may impact children's social and emotional development; and
- work closely with family members, pediatricians and other early intervention partners to recognize and address such needs.

Parents, foster parents and other protective caregivers must be given guidance and support to understand the strong sensory base to an infant's experience of interactions with people and the world in general. Provider must educate them to recognize indicators of the young child's adjustment through behavior (e.g. an infant's eating, sleeping and other bodily functions). They must be helped to understand that, as children make gains with receptive and expressive language and with cognitive development, they will have increasing capacity to identify and describe how they are reacting to or coping with new situations, how it feels and perhaps what might help them to feel better.

Service expectations: The assessment of infants, toddlers and preschool-aged children must be developmentally appropriate. Service plans must consider the strengths and needs of involved

family members. As appropriate, service plans must include elements of education, socialization, support, family counseling and the development of healthy child-caregiver relationships.

8. Preparing the Adolescent for Independent Living

The unique service needs of children who reach the age of majority while in protective state custody will be multi-dimensional. Some may continue to have traditionally-understood behavioral health needs that will be addressed through services associated with their eligibility for general mental health, substance abuse and/or serious mental illness. Problems that tend to surface in adolescence (e.g. alcohol and drug use, truancy) will likely be more common among their age-peers in the child welfare system. In addition, in order to become stable and productive adults, they may need transitional financial assistance (including, but not limited to, DES-ACYF independent living subsidy) and financial literacy, locating and securing decent housing, and connections to a first job and/or continuing or higher education. Employment, higher education and housing issues will pose significant challenges for many young people.

Some young adults will continue their involvement with CPS on a voluntary basis. CPS independent living and young adult programs offer opportunities to gradually develop skills necessary for stable, productive adult living. Many young adults, understanding they are now fully responsible for making their own decisions, have opted to forego such opportunities and cut ties with the system that may have, in their view, been “controlling my life” before now. Counseling may help these young adults to realize their decision-making power without “proving it” by cutting ties with this important lifeline.

Many young people who have been in the foster care system have expressed the recurring themes of stigma, of an overwhelming desire to be free of it, and to be seen in the world as competent and self-sufficient, independent of pity, fear, or the need for care. Many young adults will still have – or will strive to re-establish -- close connections with others from their past, such as siblings, family, friends, educators and faith communities. The behavioral health representative, in collaboration with CPS personnel, must:

- respond quickly to meet their needs
- involve the young adult’s own support systems
- plan adequately to address their needs
- stay involved in their lives, and
- help them to transition to adulthood by teaching them the skills they need to thrive and to meet their ongoing needs, including mental health issues that continue into adulthood, or which may emerge over time.

The Child and Family Team must anticipate the need to help a young person to prepare for the transition to adulthood beginning, when possible, age 16. *ADHS Practice Improvement Protocol #7: Transitioning to Adult Services* offers specific guidance and detailed tools to support the CFT in thorough planning and preparatory activities.

Service expectations: Service plans must include services, supports and resources that promote the continuation of supportive relationships and successful transitions to adulthood, consistent with ADHS policy.

SUMMARY: While this protocol describes many likely emotional responses of children, it is not exhaustive. Children may manifest a wide variety of psychological, social and even medical

problems in combination. Regional behavioral health authorities and their service providers are expected to share this understanding of the unique behavioral health and related needs of children involved with CPS, their families and caregivers; and to apply it in guiding and supporting Child and Family Teams to respond to those needs.

Service expectations: RBHAs and providers must develop and furnish sufficient behavioral health services and supports, consistent with this protocol, that will meet the needs of the child, with special attention to the timeliness, frequency, intensity, duration, and level of expertise of services provided.